CE Registration Form

Contact Information—Please complete all fields.

• First Name: _______________________________ MI: ________________________

• Last Name: ___________________________________________________________

• Business Affiliation: __________________________________________________

• Degree: ______________________________________________________________

• Office Address: ________________________________________________________

• City: _________________________________________________________________

• State: _______________________________ Zip: ____________________________

• Office Phone: _________________________________________________________

• Fax Number: __________________________________________________________

• Email Address: _________________________________________________________

Course Information

• Name of Course: _______________________________________________________

• Location of Course (if offered at multiple locations): _______________________

• Dates/Times (if a date and time selection is necessary): ____________________

Payment Information—Please complete all fields.

• Payment Method: _____ VISA _____ MasterCard _____ Check payable to UKCD CE

  o Name on Card: _______________________________________________________________________________________

  o Card Number: ____________________________ Expiration Date: __________

  o Signature: _________________________________________________________________________________________

  o Billing Address for Card: _____________________________________________________________________________

    (Street, City, State, Zip)

Form Submission Information

• Fax completed form to: (859) 257–0486

• Mail payment and completed form to: University of Kentucky, College of Dentistry Continuing Education, 800 Rose Street, Attn. Elaine Stafford, Dental Science Bldg., Lexington, KY 40536-0297

• Call (859) 323–8155 or (859) 323–8187 to register